Washington State Department of Social & Health Services

Family Caregiver Support Program

CONTACT

CLIENT IDENTIFICATION NUMBER

Section A. Contact Information

Date:	Staff:	☐ By phone ☐ In person	How did you hear about this program? ☐ Newspaper ☐ TV ☐ Brochure ☐ Website ☐ Support group ☐ Friend/family ☐ I & A ☐ Health care provider ☐ Other agency or case manager (name):

Caller's relationship to the care recipient (check all that apply):

☐ Family caregiver of an adult ☐ Grandparent/relative caregiver of child ☐ Friend/neighbor

☐ Caregiver of person with developmental disability ☐ Care recipient

☐ Provider (specify type): _____

☐ Other (specify): _____

Age of care recipient: ☐ 18 or less ☐ 19 - 59 ☐ 60+

If information call only, go to Section D. Disposition

Section B. Caregiver Identification Information

1. Caregiver's name: last, first ,

Primary caregiver: ☐ Yes ☐ No

2. Gender: ☐ Male ☐ Female

3. Address City State Zip Code:

4. Age of primary caregiver: ☐ 59 or less ☐ 60 +

5. Telephone number:

6. Specify the unpaid caregiver's relationship to the care recipient:

☐ Spouse ☐ Partner ☐ Adult child ☐ Sibling ☐ Parent ☐ Other relative

☐ Friend/neighbor ☐ Grandparent/relative caregiver of child

☐ Caregiver of person with developmental disability ☐ Other (specify):

7. Ethnicity of caregiver:

☐ African American
☐ Hispanic Origin
☐ American Indian/Native Alaskan
☐ Asian/Pacific Islander (includes Hawaiian)
☐ Non-Minority (white, non-Hispanic)
☐ Other
☐ Unavailable

8. Language used: See language codes

Language codes:

0 North American Native	12 Finnish	24 Large Print English	36 Spanish
1 American sign Language	13 French	25 Mandarin	37 Tagalog
2 Amharic	14 German	26 Mein	38 Thai
3 Arabic	15 Greek	27 Norwegian	39 Tigrigna
4 Braille	16 Hindi	28 Other	40 Ukrainian
5 Cambodian	17 Hmong	29 Polish	41 Unknown
6 Cantonese	18 Hungarian	30 Portuguese	42 Vietnamese
7 Chinese (General)	19 Ilocano	31 Puyallup	43 Yakama
8 Czech	20 Italian	32 Romanian	44 Yugoslav
9 Dutch	21 Japanese	33 Russian	
10 English	22 Korean	34 Salish	
11 Farsi	23 Laotian	35 Samoan	

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Section C. Care Recipient Information

1. Care recipient's name: last, first ,	2. Gender: ☐ Male ☐ Female	3. Telephone number:
4. Address City State		Zip Code:

5. Ethnicity of recipient:

- ☐ African American
- ☐ Hispanic Origin
- ☐ American Indian/Native Alaskan
- ☐ Asian/Pacific Islander (includes Hawaiian)
- ☐ Non-Minority (white, non-Hispanic)
- ☐ Other
- ☐ Unavailable

6. Language used: See language codes

7. Primary presenting health conditions (check all that apply):

- ☐ Neurological (e.g., stroke, Multiple Sclerosis, Parkinsons, paralysis)
- ☐ Traumatic Brain Injury
- ☐ Musculoskeletal (e.g., arthritis, osteoporosis, gout)
- ☐ Cardiovascular (e.g., heart/circulations conditions)
- ☐ Mental illness (e.g., manic depressive disorder, schizophrenia, major depression)
- ☐ Alzheimer's and related dementias
- ☐ Respiratory (e.g., asthma, emphysema, Tuberculosis, Chronic Obstructive Pulmonary Disease)
- ☐ Developmental disability
- ☐ Cancer
- ☐ Other (specify): _____

8. Is care recipient receiving case management services?

- ☐ Yes, through what agency: _____
- ☐ No

9. Narrative (attach additional sheet if necessary):

Section D. Disposition (Complete all that apply)

1. Information (caller requests simple/general information such as a telephone number, name of agency, etc.). Check areas below in which information was given:

- ☐ Respite Care
- ☐ Services other than Respite Care
- ☐ Health condition(s)
- ☐ Behavior management
- ☐ Financial
- ☐ Legal
- ☐ Medical/diagnostic
- ☐ Emotional support services
- ☐ Rehabilitation
- ☐ Placement help (out of home)
- ☐ Training
- ☐ Direct care of care recipient
- ☐ Other: _____
- ☐ Other: _____

Section D. Disposition (Continued) (Check all that apply)

2. Assistance in gaining access to services (caller requires additional information and/or assistance in understanding resources or clarifying issues). Check below if assistance provided:

☐ Referred to Respite Care, either: ☐ Fill out Respite Care Prescreening form AND/OR ☐ Refer to appropriate agency:

☐ Referred to services other than Respite Care (check all that apply):
- ☐ Financial
- ☐ Legal
- ☐ Medical/diagnostic
- ☐ Rehabilitation
- ☐ Training
- ☐ Support group
- ☐ Counseling
- ☐ Case Management; specify agency: _____
- ☐ Other: _____

☐ Support in understanding and solving problems related to services

☐ Support (emotional or practical) for the caregiver in maintaining the current living situation (e.g., behavior management, stress management, etc.)

☐ Add to mailing list (write name and address if not obtained in Sections B and C):

_____

Date done and by whom: _____

☐ Send information packet

Date done and by whom: _____

☐ Materials to add to packet:

☐ Other action (specify):

☐ FOLLOW-UP needed (may include call back/monitoring):

CHECK ANY NEEDS OR REQUESTS YOU WERE UNABLE TO MEET:

☐ Services: _____

☐ Emotional support: _____

☐ Behavior management: _____

☐ Placement help: _____

☐ Other: _____

☐ Other: _____

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Section E. Progress notes including results of follow-up (initial and date):

Section F. Activities of Daily Living (ADLs) Screening for Supplemental Services

To qualify for Supplemental Services under the National Family Caregiver Support Program (NFCSP), the care recipient (age 60 and over) must be:

1. Unable to perform at least two ADLs without substantial human assistance, including verbal reminding, physical cueing, or supervision.

   Check ADLs that require substantial assistance:

   - ☐ Eating
   - ☐ Toileting
   - ☐ Ambulation
   - ☐ Transfer
   - ☐ Positioning
   - ☐ Specialized body care
   - ☐ Personal hygiene
   - ☐ Dressing
   - ☐ Bathing
   - ☐ Self-medication

OR

2. Due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health of safety hazard to the individual or someone else.

   ☐ Requires substantial supervision due to cognitive or other mental impairment.

3. Does the care recipient meet the ADL and age (60+) criteria to receive NFCSP Supplemental Services?
   ☐ Yes ☐ No

   If no, please note in Section D. Disposition, alternative ways the needs of care recipient will be met.